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Early relationship struggles: A case study of alliance formation and reparation

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Abstract

Aim: A good alliance established during the early sessions of psychotherapy will most likely lead to a good outcome. As a result, there is much to learn from a case in which both the patient and therapist regarded the alliance as being poor for an extended period (the first 15 sessions), yet still managed to develop a solid and stable alliance and reached a successful completion of therapy. The aim is to give a close inspection of this reparation process.
Methods and analysis: Ratings on the Working Alliance Inventory (WAI) were used to guide the strategic selection of a case in which a depressed woman in her thirties sought help from an experienced senior male psychotherapist. A detailed analysis of the therapeutic dialogue brought forth what the parties expected from each other and how they responded to explicit and implicit expressions about how to proceed. Post-termination interviews revealed their subjective configurations of events in therapy and their corresponding reflections.
Findings and discussion: Important steps and hallmarks of the alliance formation and reparation were identified: (i) Early in the process, incompatible expectations about what the relationship could achieve led to repetitious struggles. (ii) Their conflicting notions came forward in a more open dialogue about two specific issues (her medication and sick leave). (iii) Through the recognition of different viewpoints they were able to expand on their interactional pattern and develop playful ways to explore her decision making in everyday life. (iv) Temporary breaks seemed to consolidate her autonomy. (v) Late in the course of therapy, the therapist introduced a literary metaphor that seemed to further consolidate the alliance.

Early relationship struggles: A case study of alliance formation and reparation

In clinical work, it is widely recognized that dealing with many types of difficulties related to the therapeutic alliance is essential to the course of therapy (Bordin, 1994; Orlinsky, Rønnestad, & Willutzki, 2004; Safran & Muran, 2000; Safran, Muran, Samstag & Stevens, 2002). Decades of research on the relationship between psychotherapists and patients has shown that the quality of the therapeutic alliance, especially as perceived by the client, correlates positively with the outcome (e.g. Castonguay, Constantino & Holtforth, 2006; Martin, Garske & Davis, 2000), and standardized measures of alliance during the third to fifth sessions have proven to be a consistent predictor of outcome (Barber et al., 1999; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Horvath & Symonds, 1991). Nevertheless, it has also been commonly experienced among clinicians that with some patients, particularly patients with more severe psychological conditions, an initially poor alliance which has endured for many sessions was eventually repaired and turned into a good one. The investigation of such cases is important, as these represent both a challenge in our clinical work and can add to our knowledge about the formation of psychotherapeutic alliance.

In the present case, the patient and therapist initially struggled with severe difficulties in finding a common ground on how to work together. The standard measure for the quality of the alliance (WAI) revealed that the pattern of the therapist's and patient's evaluation were almost identical, although the therapist rated the alliance somewhat lower than the patient. They both rated the alliance in the lower range (scores: 3-4) during the first 12 to 15 sessions, though there was a gradual improvement on both sides for the following sessions, and at the end, both parties rated the alliance in the upper range (scores: 6-7). Both

the patient and the therapist rated the task/goal components lower than the bond. It was this pattern of a poor start, followed by a gradual improvement that caused us to nominate the case for further inquiry with the expectation that it would bring forth a better understanding of how and when repairs may take place. In the aftermath, we have explored what characterized the poor alliance and what made it this way for a series of sessions, and how the patient and therapist managed to cope with the difficulties to create a successful therapy. On the basis of Safran and Muran's (2000) and Safran, et al.'s (2002) extensive work on the alliance rupture and repair process, we expected to find that the solving of conflicts and therapeutic meta-communication would play an important role in this process.

Method and design

The case is selected from a larger psychotherapy research project called "An intensive process-outcome study of the interpersonal aspects of psychotherapy" (Rønnestad, 2006) at the Department of Psychology, University of Oslo, Norway. The project includes 18 highly experienced therapists and 40 patients.

Data material

Quantitative data. Independent ratings from both the patient and therapist on the short version of the Working Alliance Inventory (WAI; Hatcher & Gillapsy, 2006; Horvath, 1994a, 1994b; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) allow for a first inspection of the quality of the alliance across sessions from the initial stages to the termination of therapy. The WAI is a pan-theoretical measure of the therapeutic alliance, which comprises Bordin's (1979, 1994) three aspects of the working alliance: agreements on the therapeutic goals, consensus with respect to the tasks that make up therapy, and an emotional bond between patient and therapist. It consists of 12 items rated on a seven-point

Likert scale. In the present study, both the patient and therapist completed the questionnaire after sessions 3, 6, 12, 20, and at every 20th session thereafter. In addition, the Outcome Questionnaire 45 (OQ-45; Lambert & Burlingame, 2004) and the Inventory of Interpersonal Problems (IIP-C; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) were used as additional outcome measures.

Qualitative data. All sessions were audio recorded which gives the opportunity to observe the therapy process over a period of time. After every session the patient and therapist separately wrote a small reflection note in which they answered the questions: "What was the most important aspect of this session and why?" These notes gave an experience-based description of what occurred in the sessions, and gave some possibilities for strategic thematic searching within the database. After termination, both the patient and therapist were interviewed about their experiences and reflections concerning the therapy. The interview guide was organised around topics concerning the therapeutic process and helpful aspects of treatment. The interview may be described as semi-structured, and the interviews lasted for approximately one hour. The data collection procedures are independent of the case analysis in this paper.

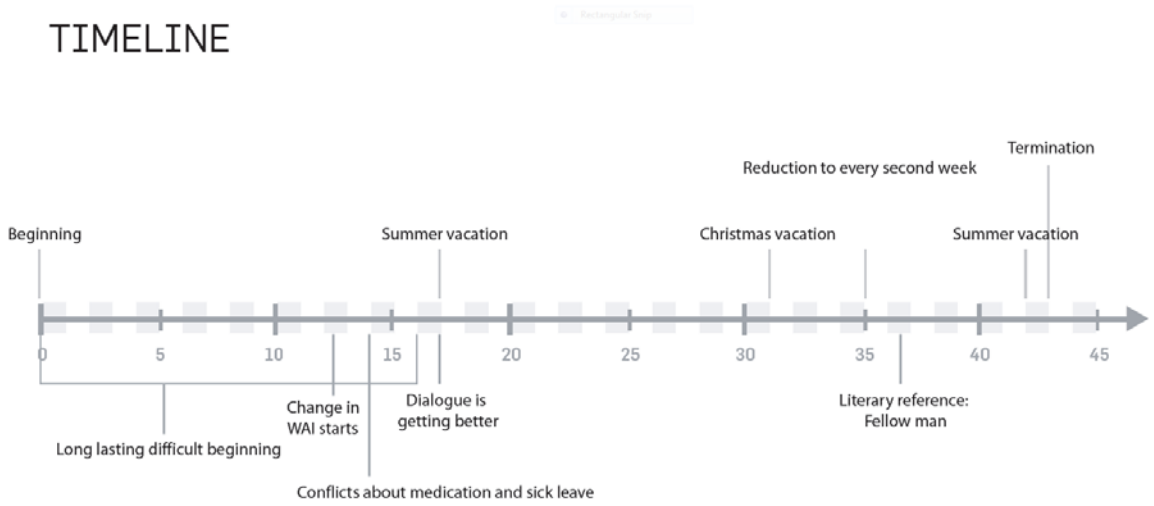
Subjects

The patient. Marian is a woman in her thirties, who was referred to a psychotherapist after two hospitalizations a few years earlier. The hospitalizations were due to severe depression accompanied by suicidal thoughts (the first time) and psychosis (the second time). When she entered the research project and started therapy, she was diagnosed with Bipolar I disorder, currently moderately depressive and used anti-depressant and mood stabilizing medication (there was a change in her medication during therapy). Marian is single and has no

children. Directly before the referral, her father died, and she and her live-in boyfriend broke up. Her mother lives in another part of Norway and she has three siblings, one of whom has severe mental problems. Marian has an artistic profession and started therapy while on sick leave, though she gradually started working again during the process of treatment. At pre-treatment, Marian's score on the OQ-45 was 89. At treamtent termination her score was 53, which indicates a clinical significant change.

The therapist. Paul is a man in his fifties, who works in a public outpatient clinic. He is a clinical psychologist, and is an experienced teacher and supervisor in psychology. His psychotherapeutic orientation may be defined as eclectic and integrative, with traces from psychodynamic, systemic and cognitive thinking.

The therapy. The therapy was conducted in an outpatient setting, and the patient paid a low standard fee for the consultations. There was no pre-defined time limit for the treatment. The therapy lasted for 19 months, with a total of 43 sessions. The frequency was one session per week the first year, and one session every second week for the last six months.



Analysing interactions and reflections (therapy sessions and post-termination interviews)

Our design allows for the possibility of data triangulation (Denzin, 1989), i.e. interviews with the patient and the therapist asking for their subjective configuration of the events in therapy and their corresponding reflections, in addition to audio recordings allowing for observations of the dialogue according to the chronology of the therapy sessions. To study both patient and therapist makes room for different perspectives on the same process. When analysing the interviews, we wanted to stay as close to the informant's concrete and contextually anchored experience as possible, while exploring their own views of what felt significant in the therapeutic process (Elliot & Shapiro, 1992; Giorgi & Giorgi, 2003; Smith & Osborn, 2003; Smith 2007). We also wanted to connect their experiences with what we observed in the therapy sessions, and our aim was to identify patterns of interaction as well as important themes in the dialogue. The analytical questions were: (i) How and when does the patient express something about his/her wishes for the therapeutic relationship? (ii) How and when does the therapist express something about how their relationship can or should be? (iii) How do they react to each other's initiatives?

Even though we tried to stay as close as possible to the informants' own descriptions, in addition to avoiding theoretical concepts, both the formulation of research questions and the reading of the data will necessarily be affected by the specific experiential horizon of each researcher (Gadamer, 1965; Smith, 2007). In accordance with reflexive methodology, we use the dialogue with the participants' views in order to explore and reflect on our own pre-understanding (Alvesson & Sköldberg, 2000; Finlay, 2003). Our background and training as psychotherapists, together with our interest in relational therapy theories, have contributed to both setting up a relational case study and seeing relational themes in the material. This background has made it possible for us to reflect upon the case in the manner which we have,

while at the same time representing a bias that could cause us to overlook or leave out other important themes.

We used the patient's and therapist's WAI scores, as well as their reflection notes and statements in the interviews to strategically select sessions where the therapeutic alliance was rated as low, sessions when the alliance started to improve, sessions which the participants described as good, plus sessions at the beginning and end of treatment. Thus, 16 of the 43 sessions were chosen for a more detailed analysis, with the use of a hermeneutically modified method for systematic text condensation (Malterud, 1993; 2001). The data analysis proceeded through the following steps: (i) We listened to and transcribed the recordings of the interviews and the 16 selected sessions. (ii) We read through the written material several times to better obtain a basic sense of the struggles and changes in the relationship.(iii) In the sessions we brought attention to indirect as well as direct proposals from each party, and their subsequent responses to each others proposals. We identified units of meaning which represented different aspects of what had taken place both in the sessions and in terms of the informants' experiences. We looked for connections between what we observed in the sessions and how it was experienced and reflected upon by the participants in the aftermath. This was done on a separate basis by the first two authors and then discussed in conjunction with the third author. (iv) The last step consisted of further categorization and selection of quotes to include in this presentation in order to disseminate the course of development and the specific changes in the relationship. This condensation is supported with some general descriptions of the course of events, and the narrative dimension is utilized for structuring and interpreting the data (McLeod, 2001; McLeod & Balamoutsou, 2001). We have chosen a chronological presentation of the course of therapy, with focus on central relational themes. The analysis was carried out on a technical basis with the assistance of Nvivo 8 software (QSR, 2008).

The researchers

All three authors are psychologists and work as researchers. The first author (MR) has 12 years of clinical experience. The second author (MSH) has eight years of clinical experience, and both have an interest in interpersonal and relational psychodynamic approaches and in psychotherapy integration. The third author (HH) has more than 30 years of clinical experience, and her therapeutic work is theoretically informed by developmental and interpersonal psychology. The interview with the patient was conducted by MSH, and the therapist was interviewed by another researcher in the project.

Ethics

This study (Rønnestad, 2006) was approved by the Regional Committee for Medical and Health Research Ethics (Region South-East) and by the Norwegian Social Science Data Services. Details about the informants have been changed to provide anonymity. The participants read a late draft of the paper both to give a final consent and to ensure that the quality of their experience was conveyed in the analysis and presentation. Both participants approved the manuscript and felt that their experiences were well represented. The patient had some minor comments which are incorporated.

Findings

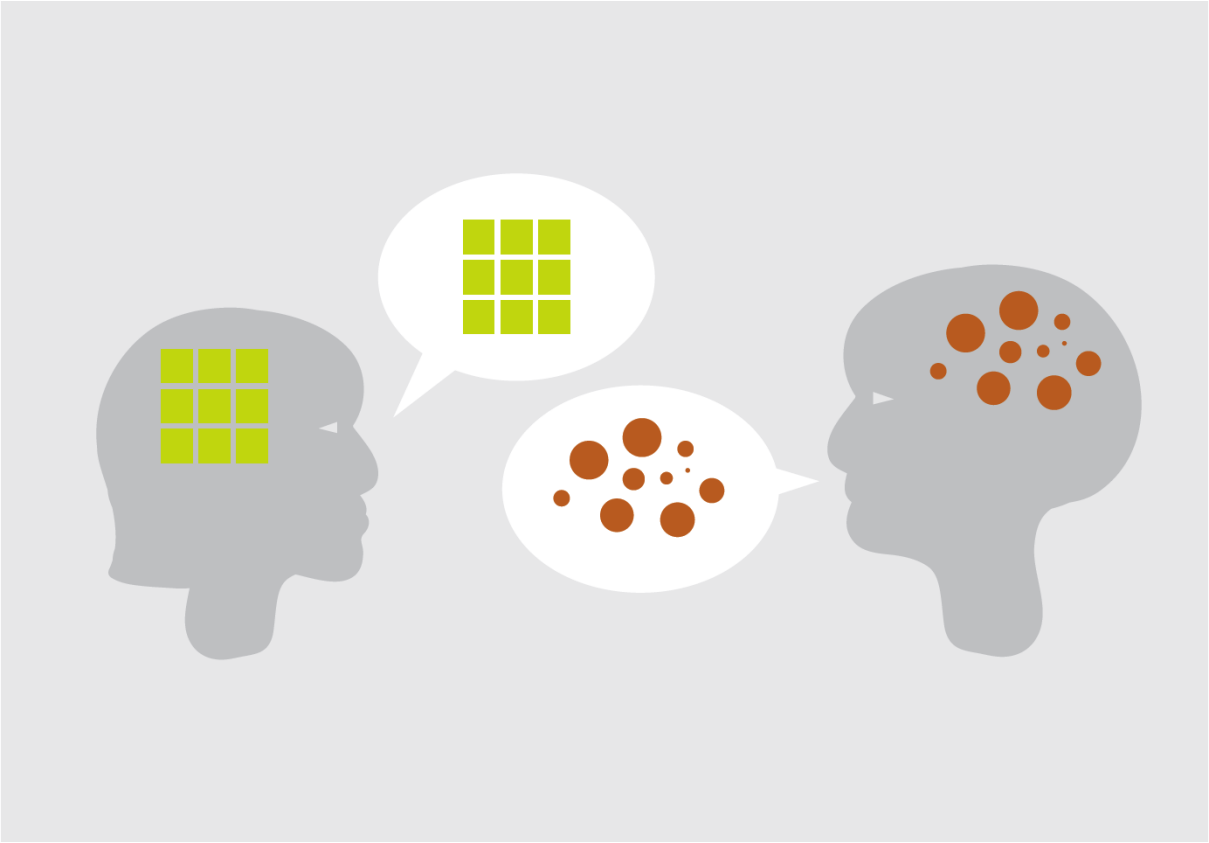


Figure II – illustration about here

Early relational struggle and discrepant expectations

Marian and Paul started out with quite differing expectations of what therapy should be like and how they were supposed to behave. Both parties firmly held on to their own expectations and wishes, and their initial relationship struggles may be described as a type of power battle. Marian had heard that this particular outpatient clinic had a good reputation. Before starting treatment, she had sent a letter to the therapist in which she described her problems. In the interview, she said that in the beginning she had experienced the therapist as being arrogant, authoritarian and lacking empathy. Her first experiences had left her with little hope that the therapy could be useful, and she described a feeling of aimlessness.

(Interview)Patient: In the beginning I wasn't comfortable with him. He challenged me in ways I disliked. Maybe I was defensive, and I wondered if he was taking me seriously and if he understood how badly I felt.

She also reflected upon the early struggles in more ambiguous ways. She tells about a friend who had told her that this might be the kind of therapist she needed, one who did not stroke her hair, but instead challenged her. *She continues: He saw me as being tidy and neat. He didn't quite fall for my charm, he didn't at all say: "Poor you".*

Paul's pre-understanding was coloured by the referral as well as the letter she had sent him, which he experienced as demanding, as if he was supposed to eradicate her pain. He experienced her as a somewhat defensive person who was passively waiting to receive help. His therapeutic goals were more in the direction of challenging her, and by this, helping her to develop agency and autonomy.

(Interview) Therapist: She played a dependent and passive role for herself. I wanted a bond built on a more adult relationship. I didn't want her to like me because I was careful and helpful, but because I dared to challenge her... The first phase was a period of risk, when she was appealing and all the time going back to her letter where she described her troubles. From time to time, I doubted that the therapy could become useful.

Negotiation about how they could work together in therapy and what their relationship could be like was a major topic in this early phase. A recurring theme in this dialogue was how she could make better use of the sessions.

(Session 11) Patient: Nothing gives me any pleasure. That's the problem. I think about how scary life is all the time.

Therapist: That's not a very useful way of thinking, is it? To think about how negative everything is, even when you take part in positive events.

Patient: No.

Therapist: It is as if you put something bad into every situation and produce negative thoughts about it.

What is typical of this early troublesome dialogue is that Marian talked extensively about her suffering, and Paul responded by showing scepticism about her way of thinking, whereupon she gave short answers to his responses. Marian seemed to explore Paul's willingness to sympathize with her suffering, while the therapist tried to guide her to new ways of thinking about handling her life. This type of struggle can be easily observed, and both parties refer to it in the interviews. Still, in the sessions it has not been explicitly recognized and addressed as an ongoing conflict about how they could work together.

A conflict they left behind and a conflict they solved

There is a notion that by solving relational ruptures, the alliance can be repaired (Safran & Muran, 2000; Safran, et al., 2002). In this case, when open conflicts appeared in the conversation, it was about two rather specific issues. In two subsequent sessions (14 and 16) Marian brought forward two requests, which were turned down by Paul. She then felt rejected and was able to act on her feelings, hold on to what she felt was reasonable, and tell Paul that she could not accept that he was turning her down. The first conflict emerged when Marian wanted direct contact with a psychiatrist to discuss her medication (Session 14). Paul stated

explicitly that he wanted there to be a definite assignment of responsibility in order to reduce confusion for the patient. He wanted her to talk with her general practitioner about any medication she might need and to concentrate on the psychotherapy. When medication is discussed in the sessions, the tone is sometimes agitated.

(Interview) Patient: I wanted direct contact with a psychiatrist and was frustrated because the therapist refused. I was provoked and disappointed, and felt powerless. He didn't recognize my needs. Then he was very arrogant in terms of his language and attitude, which became quite a crisis in the patient-therapist relationship. I finally managed to get an appointment with a psychiatrist, but it was far from optimal.

Marian was dissatisfied with the way Paul responded to her question. She managed to get an appointment with a psychiatrist, but she was still critical of the way Paul handled this matter when she reflects upon it in retrospect. Paul though, was provoked by Marian and felt degraded and mistrusted.

(Interview) Therapist: She was eager on medication. She made it clear that this was something I had not mastered, and she wanted to see the professor. I was on the edge of feeling degraded about being thought of as some type of errand boy for the psychiatrist. There was a tug of war in the relationship.

They did not solve this conflict. Instead they seemed to leave it behind and turn to other themes. In the sessions they did not talk explicitly about relational strains. Even though they did not achieve an agreement about the medication arrangements, they seemed to leave the conflict behind and continued therapy.

The second conflict was about sick leave and how fast Marian was supposed to return to full time work (Session 16). Marian wanted a longer period on sick leave, while Paul was pushing her to go back to work. His main arguments were that she should take responsibility and obtain a sense of mastery and self-esteem. Their interactions in session 16 as well as 17 demonstrate how each of them are repeating their different points of view about whether she will profit from a plan to work or not. In Paul's retrospective reflection, however, this conflict was crucial in the process of establishing a good alliance.

(Interview)Therapist: One of the crucial points that drove the therapy forward was a fight we had about her being able to work, where she first wanted to prolong a partial sick leave, but where I felt I had to stand up and challenge her. And that was a success. I think it really strengthened the alliance and brought us more wholeheartedly to the same team, instead of her fighting against me.

He states both in the interview and the sessions that her way of defining herself as being ill fitted as far as her tendencies to back out and give up responsibility. Marian doesn't tell explicitly about this conflict in the interview. But she talks about Paul's attitude towards being sick versus healthy.

(Interview) Patient: He gave me some good suggestions on normality. He was generous about normality, for instance in terms of my diagnosis. He challenged me not to worry about that label. He was very eager to declare me well and get me out of the mental health system and push me towards just going on with my life.

In retrospect, Marian seems to have experienced this generosity towards normality as affirming, and the challenge to go back to work as a gentle push. She gradually returned to full-time work and said she was satisfied with her situation, and Paul comments in the interview that this push was well-timed.

No doubt both parties experienced these conflicts, and both were able to reflect on what happened in the aftermath. In the ongoing interaction however, they did not talk about their feelings. They rather settled the conflict by keeping to their divergent points of view, and then move on to other topics. Interestingly enough this change in their interactional pattern from just indirect conflicts to more open fights as well, seemed to add a new dimension to the ways they could handle her inclination to appeal to his sympathy and his wish to challenge her to reach more autonomy.

Playful dialogues about her struggles with decision making in everyday life

There were some themes within the dialogues in which they responded to each other in more open and playful ways. In the selected sessions, we found three extensive dialogues in which they thoroughly and playfully discussed her struggles to make decisions in everyday life (i.e. to buy a pair of shoes, to put a picture on the wall, and to plan for a holiday).

(Session 16) Patient: I had a picture to put up on the wall. I'm a perfectionist, if it was less than perfect I would keep looking at it and would torment myself every day. A friend who was with me said: Let's just do it. So I called my mother, and she said to wait.

Therapist: You called your mother because you were planning to put up a picture on the wall? And then you suddenly had two different opinions to consider.

Patient: My friend was already into it, and I thought, okay, we'll just do it. It ended up with a huge hole in the wall, and now I can hardly think of anything else.

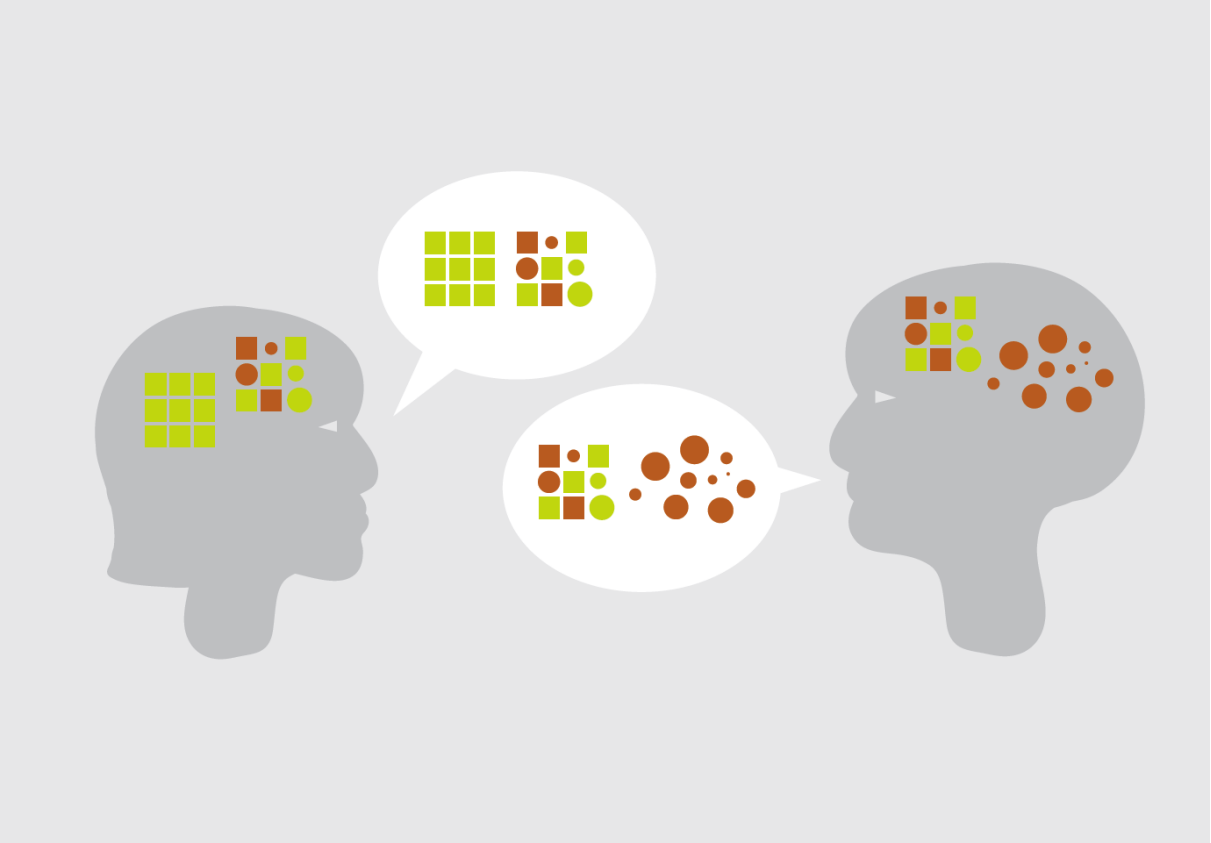
Therapist: (laughs) Sorry I'm laughing.

Patient: Feel free, it's mostly comic, I can see that for myself. I shouldn't have let her, but her eagerness overruled me. And now it torments me. For a moment last night I had a glimpse of light: I can look at it as a lesson I had to learn. When I look at the hole I can think of it as an example of the importance of making my own decisions. I have to make sure that what I feel is right and not leave it to others because it is comfortable.

We discovered that they mutually looked at her ways of dealing with these situations, and seemed to find meaningful and playful ways to explore more existential themes while staying close to the "small things". Paul did not necessarily interpret these connections, yet the dialogue at the implicit level seemed to transcend the "small" themes. They also worked with small emotional nuances, for instance, to indulge oneself with good things and to recognize the difference between just having a good time and being manic and between being generous and reckless. Paul was rather consistent in affirming adaptive parts of her behaviour before exploring what might be maladaptive.

These findings were what surprised us the most, because neither the reflection notes nor the interviews with patient and therapist guided us to look for these playful dialogues.. The first instance of this mode of interaction appeared early when their relational struggles were still dominating. After the open conflicts, however, they seemed to have created such an interactional pattern that they could both rely on and return to over again.

Figure III - illustration about here



Vacation breaks as consolidation

Therapy which lasts over time always involves temporary interruptions of various types, and these breaks in therapy seem to have been a tool for testing one of the main themes in the therapeutic dialogues: her independence and autonomy. At the same time, it also seems to have functioned as a way to highlight and consolidate the therapeutic alliance.

(Interview) Therapist: The breaks have been more of a consolidation than a disruption, to mark the mastering of her own life. I think it contributed to her self-esteem.

(Session 18 (the first session after the first summer vacation)) Therapist: During the summer, did you think about what psychotherapy means to you and what you want it to be?

Patient: I have. An always reoccurring theme is getting back to work, getting things done, taking responsibility and so on. In the beginning of this therapy, I totally lacked joy, and you tried to find out what I like to do, which was impossible. Now I feel that I have moved a step further. There are small things I still want to experience in my life (cries). I still want to experience sunny days and nice summer evenings and music and...

Therapist: That's what we are going to spend time on now!

Patient: Yes! (cries)

Therapist: Yes. I really like to be with you in places where your commitment and emotions are.

In the sessions after vacation, the dialogue focused more explicitly on the tasks and goals of therapy, and the therapeutic alliance seemed to be consolidated rather than disrupted by the break and the following reestablishment of contact. that she had tried some of the strategies they had worked on in therapy. She made independent decisions, put limits upon relatives and exposed herself to emotional and interpersonal risks which resulted in valuable experiences. The dialogue between them seemed to be experienced as vital and meaningful, far removed from the struggles early in the process.

Consolidation through a literary metaphor: Fellow Man.

In the interviews, both Marian and Paul mentioned the use of a literary metaphor from Olav Duun's novel "Fellow Man" (Duun, 1929/1976) as an important occurrence in the therapy.

(Interview) Patient: The therapist punctured my idea that I am larger than life. I don't have the power to decide for instance what my brother and my mother should do, even if I

clearly see their mistakes. Then he came along with that parallel to Ragnhild in Olav Duun's "Fellow Man". Ragnhild felt she had a mission to save her husband and ended up killing her father-in-law. This parallel was the key I needed. Suddenly, I acknowledged that it was beyond my power to rescue them. He took it away from me. I had to realize when one is not enough, and let it be. I felt he seriously worried about me, he gave me frank advice.

(Interview) Therapist: You know Ragnhild in "Fellow Man"? She had ideas about superiority, and it ended in tragedy when she killed her father-in-law. This was parallel to Marian's role in her family and the themes in her psychotic experiences, that she had a special mission to save the others. In the last part of therapy, she had some aha-experiences and backed away from the idea of saving her family. It was inestimable to hear her talk about it. To be sure, medication had its effect, but I think I mattered too. We talked about that novel, which I think was a turning point. It also gave meaning to that manic depressive move: If you feel you have a special mission to complete and experience that it is absolutely impossible to carry out, you don't go as far as Ragnhild did because if you do you will be on a low that is so painful that you will have to set reality aside and rise up in manic behaviour. My main goal is to always attempt to create meaning.

(Session 37 (the session in which the metaphor was introduced)) Patient: This is really useful. I can see the parallel. I'm on a mission, almost like Jesus. Actually, it's been my duty in the family to bring light to the others.

Therapist: The little sunbeam, someone really special.

Patient: I've always been special. However, when I got that flash where I realized what everyone should do, I couldn't get them to do it. It went too far.

Therapist: So it wasn't so farfetched to talk about Ragnhild, who lost her grip.

Patient: That was a very good metaphor, incredibly appropriate.

Marian talks about this metaphor as being crucial and Paul emphasizes therapy as a way of meaning making process. In their dialogue about this literary metaphor they are not only "looking at her" together, but rather two human beings sharing important existential meanings and experiences.

Discussion

Despite the difficult beginning in this therapeutic relationship, the patient and therapist found ways to work together and the therapy was successful in the end. Why did they continue therapy despite the continuous struggles?

As expected, the emergence and recognition of conflicts seemed to be important. Contrary to what we expected, therapeutic meta-communication as described by Safran & Muran (2000) was not part of the reparation process. Despite this, it seems as the conflict contributed positively to change. It appears as if the power imbalance in the relationship was neutralized through these conflicts and the unmet expectations and goals of both parties were figured out and dealt with. The patient disagreed with the therapist and was able to say so. This growing mutuality within the relationship was probably important for the resolution of conflicts and the improvement of the working alliance. When the patient was challenged to go back to work and realised she was able to do so, she seems to have experienced the therapist's challenge as an affirmation of her ability and mastery. Likewise she seems to have used what she describes as his generosity towards normality.

An interesting finding in this case was that the therapeutic dyad seemed to find meaningful ways of being together when they repeatedly and playfully explored the patient's difficulties in making small everyday decisions. They were mutually involved in these explorations and seemed rather consistent in the ways they stayed with specific incidents and explored them. Since they followed this interactional pattern for several sessions, they were able to generalize their experiences and share the result when joy and despair collided. The way of staying with the detailing of "small things" follows Levenson's (1988; 1989) encouragement to pursue the particular and engage in patients' real-life experiences. Through these explorations, the therapist challenged the patient's pattern of safety seeking manoeuvres and together they shared a rather rough humour. Through this, they explored emotional nuances, and the therapist normalized the patient's experiences.

These dialogues are alliance-building negotiations that do not address relational difficulties. According to Winnicott (1971), psychotherapy has to do with two people playing together, and he sees the therapist's primary goal as bringing the patient into a state of being able to play: Play belongs to health. In the play mode, there is creativity, diverse possible meanings and space for development. It is reasonable to believe that these playful and meaningful dialogues were important parts of what made them, and especially the patient, endure the relational strains.

An important therapeutic goal was to increase the patient's independency and agency. The vacation breaks seemed to function as an affirmation of independence, as well as of the therapeutic alliance. Tasks and goals were made explicit in the dialogue following temporary breaks, and the relationship seemed to be marked by a more positive affect and engagement. The breaks as consolidation were thoroughly discussed in the sessions, and this can be thought of as a variant of the meta-communication of disruption and repair (Safran & Muran 2000).

The therapist highlights therapy as a process that creates meaning. The construction and negotiation of meaning is a central human activity (Bruner, 1990), and to experience meaning is closely connected with psychic health. Fairly late in the treatment process, the therapist brought in a literary metaphor, which may be seen as a final and explicit consolidation of a relational development that had taken place through many small steps over time. The metaphor is multi-layered. In this episode, the patient and therapist seemed to become closer and more equal by sharing basic human experiences, as well as a shared interest in literature. For the patient, the metaphor was experienced as a key which opened up a new understanding of various themes in her life. It gave her a new perspective on her roles and responsibilities within her family, as well as to the dilemmas she was struggling with in her previous psychotic episode. It also gave her the ultimate proof of engagement and empathy from the therapist. Not as a kind of soothing she would crave because of her misery, but instead as a contribution to her own self-understanding and change in the approach to her own mission in life. Seen from a post-therapeutic position, the initial struggles are still there to be remembered, though the configuration of this early period in therapy will act more as a contrast. The mismatch they endured for several sessions is actually proving the gradual change in their relationship that followed.

In conclusion there are a few more general lessons from this case that we will like to bring to attention. They are both methodological and substantial.

Empirical studies of alliance formation and reparation should preferably rely on a combination of interactional data and reflective data from both therapist and patient. The chronology and the mechanisms of change could only be pinpointed with such a combination of sources. The clinical literature is more often based on the reflections from the therapist and how the same therapist is interpreting the conduct of the patient. Therefore the normative

value of reflections may come to overshadow what is really going on, how it is handled through the interactional patterns, and how these two aspects combine.

A case analysis will bring a condensed and strictly prioritized version of a psychotherapy process. Several elements are necessarily left out, and this may work both as weakness and as strength. This case, as well as other cases, may represent a challenge to prevailing norms for how psychotherapy works and the ways in which a poor working alliance may be repaired. Exploration of other cases and comparisons across cases could contribute to further nuances.

This exceptional case brought attention to how enduring incompatible notions on how to work together as therapist and patient may be changed. The transition to a more explorative and supportive pattern of interaction will not be fully dependent on metacommunication and a reflective search for new ways of being together. An open disagreement and direct fights may work to install a better reciprocity and autonomy for both parties, if they are – as they were in this case – able to accept and respect divergent positions. In the more playful atmosphere it is possible to enjoy and utilize different points of view.

Strong emotional experiences of sympathy and understanding are often experienced as turning points. There is, however, reason to believe that such turning points are working to consolidate changes that have already taken place, rather than conceiving them as causal explanations for changes to happen. The power of the metaphor, the condensed expression of shared understanding and corresponding affects is rather the result of something that is already achieved on the level of repeated interactions.

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